APPENDIX A

ITEM-BY-ITEM TIPS FOR OASIS ITEMS ASSESSED IN VIGNETTES

This appendix includes selected pages from the Item-by-Item Tips presented in Chapter 8 of the *OASIS Implementation Manual*. The first section contains OASIS items assessed in the vignette depicting the functional status of Mr. Domino (M0690, M0700, M0710, and M0720). The second section contains the OASIS items assessed in the vignette involving Mrs. Bean's mental health status (M0560, M0570, M0580, M0590, M0600, M0610, and M0620). The viewer can refer to this appendix to better understand the OASIS responses for each item.

Vignette 1: Mr. Thomas Domino

Functional Status Item-by-Item Tips

This section of Appendix A contains OASIS Item-by-Item Tips for functional status items assessed in the vignette involving Mr. Domino (M0690, M0700, M0710, and M0720).

OASIS ITEMS M0640 through M0820: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

The next group of OASIS items (M0640 through M0820) addresses the patient's functional status. Level of functioning is an important indicator of the patient's ability to remain in the home setting, as the goals of many home care interventions are to assist the patient to restore capability or to maintain maximum capacity as long as possible. Patient functioning is not the domain of only one professional group, but typically requires coordinated efforts among disciplines to achieve functional goals.

Activities of Daily Living (ADLs) include basic self-care activities (e.g., bathing, grooming, dressing, etc.), while Instrumental Activities of Daily Living (IADLs) include activities associated with independent living necessary to support the ADLs (e.g., housekeeping, laundry, shopping, etc.). IADLs usually require some degree of both cognitive and physical ability. Because home care patients have health-related needs, OASIS IADL items include management of medications and health-care related equipment.

The clinician should complete the OASIS items according to the patient's ABILITY, not necessarily actual performance for the defined item. "Willingness" and "compliance" are not the focus of these items. The patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink, should be scored on ability to bathe in tub/shower, not actual performance.

These items address the patient's ability to safely perform the specified activities, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a wholistic perspective in assessing ability to perform ADLs and IADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or hearing, pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry).

The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies, choose the response describing the patient's ability more than 50% of the time.

Direct observation, supplemented by interview, is the preferred method for assessing a patient's ADL and IADL abilities. If direct observation of an activity is not possible, item score(s) should be based on all observed and reported information available. Specific assessment strategies for each OASIS ADL/IADL item are included with the item definitions.

All OASIS ADL/IADL scales present the most independent level first, then proceed to the most dependent. The word "unable" is underlined the first time it describes a change from "able" to "unable" in the responses. Read each response carefully to determine which one best describes what the patient is able to do.

The "current" ADL/IADL status must be completed for all assessments. "Prior" status is included for start (or resumption) of care. Prior refers to the patient's status 14 days before the start/resumption of care. Adhere rigidly to the 14-day criterion: if the patient was in a hospital at that time, describe the ADL/IADL status as of that day. Obtaining prior status information nearly always requires an interview approach.

OASIS ITEM:

(M0690) Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Prior	Current			
☐	☐	0	-	Able to independently transfer.
☐	☐	1	-	Transfers with minimal human assistance or with use of an assistive device.
☐	☐	2	-	Unable to transfer self but is able to bear weight and pivot during the transfer process.
☐	☐	3	-	Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
☐	☐	4	-	Bedfast, unable to transfer but is able to turn and position self in bed.
☐	☐	5	-	Bedfast, unable to transfer and is unable to turn and position self.
☐		UK	-	Unknown

DEFINITION:

Identifies the patient's ability to safely transfer in a variety of situations. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient requires standby assistance to transfer safely, or requires verbal cueing/reminders, then response 1 applies.
- Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (e.g., a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities).
- If the patient is bedfast, the ability to turn and position self in bed is assessed.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about transferring ability. Observe the patient during transfers and determine the amount of assistance required for safe transfer. If ability varies between the transfer activities listed, record the level of ability applicable to the majority of those activities. When the patient demonstrates ambulation/locomotion, shows the clinician to the bathroom/kitchen, and demonstrates ability to get into and out of tub/shower, transferring can be assessed simultaneously.

OASIS ITEM:

(M0700) Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior	Current			
☐	☐	0	-	Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
☐	☐	1	-	Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
☐	☐	2	-	Able to walk only with the supervision or assistance of another person at all times.
☐	☐	3	-	Chairfast, unable to ambulate but is able to wheel self independently.
☐	☐	4	-	Chairfast, unable to ambulate and is unable to wheel self.
☐	☐	5	-	Bedfast, unable to ambulate or be up in a chair.
☐		UK	-	Unknown

DEFINITION:

Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient requires standby assistance to ambulate or requires verbal cueing/reminders, then response 1 or response 2 applies, depending on the quantity of assistance needed.
- Responses 3 and 4 refer to a patient who is unable to ambulate, even with the use of assistive devices and assistance. A patient who reports or demonstrates ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 3 or 4, based on ability to wheel self.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, and assess if patient should use a walker or cane for safe ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to safely propel wheelchair independently.

OASIS ITEM:

(M0710) Feeding or Eating: Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**

Prior	Current			
☐	☐	0	-	Able to independently feed self.
☐	☐	1	-	Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet.
☐	☐	2	-	Unable to feed self and must be assisted or supervised throughout the meal/snack.
☐	☐	3	-	Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
☐	☐	4	-	Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
☐	☐	5	-	Unable to take in nutrients orally or by tube feeding.
☐		UK	-	Unknown

DEFINITION:

Identifies the patient's ability to feed self meals, including the process of eating, chewing and swallowing food. This item excludes evaluation of the preparation of food items. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- Responses 3, 4, and 5 include non-oral intake.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Determine the amount and type of assistance that is provided to the patient while he/she is eating. During the nutritional assessment, determine whether special preparations (i.e., pureeing, grinding, etc.) must occur for food to be swallowed or whether tube feedings are necessary.

OASIS ITEM:

(M0720) Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals:

Prior	Current			
☐	☐	0	-	(a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
☐	☐	1	-	Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
☐	☐	2	-	Unable to prepare any light meals or reheat any delivered meals.
☐		UK	-	Unknown

DEFINITION:

Identifies the patient's physical, cognitive and mental ability to plan and prepare meals, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- Response 1 indicates patient can intermittently (i.e., sometimes) prepare light meals, while Response 2 indicates patient cannot prepare light meals.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan and prepare light meals even if this task is not routinely performed. Does the patient have the cognitive ability to plan and prepare light meals (whether or not he/she currently does this)? Utilize observations made during the assessment of cognitive status, ambulation, grooming, dressing, and other activities of daily living (ADLs) to assist in determining the best response to this item.

Vignette 2: Mrs. Martha Bean

Mental Status Item-by-Item Tips

This section of Appendix A contains OASIS Item-by-Item Tips for the mental status items assessed in the vignette involving Mrs. Bean (M0560, M0570, M0580, M0590, M0600, M0610, and M0620).

OASIS ITEM:

(M0560) Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

DEFINITION:

Identifies the patient's current level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Refers to patient's usual level of functioning.
- Level of cognitive impairment increases as you move down the list of responses.

ASSESSMENT STRATEGIES:

The patient's description of current illness, past health history, and ability to perform ADLs and IADLs allows the clinician to assess cognitive functioning through observation. If the patient is having trouble remembering questions, ask if this is common or because a stranger is asking a lot of questions. Does the patient have trouble remembering friends and/or relatives' names? Does the patient forget to eat or bathe, or get disoriented when walking or traveling (in a car) around the neighborhood or city? If there is a caregiver in the home, gather information from that person also.

OASIS ITEM:

(M0570) When Confused (Reported or Observed):

- ☐ 0 - Never
- ☐ 1 - In new or complex situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive

DEFINITION:

Identifies the time of day the patient is likely to be confused, if at all.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If it is reported that the patient is "occasionally" confused, identify the situation(s) in which confusion occurs.
- "Nonresponsive" means that the patient is unable to respond.

ASSESSMENT STRATEGIES:

Information can be collected by observation or by report. Observe patient's response to questions about current health status, past health history, symptoms, and ability to perform ADLs and IADLs. Ask the patient whether or not he/she ever feels somewhat confused (e.g., "you don't know where you are or how you got here"), and under what circumstances that occurs. Is there a change in attention span? Has recent memory declined? Mild confusion can be masked in patients with well-developed social skills, so careful assessment is needed. If a caregiver or family member is present, they may be able to describe their observations.

OASIS ITEM:

(M0580) When Anxious (Reported or Observed):

- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

DEFINITION:

Identifies the frequency with which the patient feels anxious.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- "Nonresponsive" means that the patient is unable to respond.
- Responses appear in order of increasing frequency of anxiety.

ASSESSMENT STRATEGIES:

Information can be collected by observation or by report. Observe posture, motor behavior, facial expressions, affect, and manner of speech. Ask the patient if she/he ever has episodes of feeling very anxious about things. Does the patient wake up at night feeling fearful and anxious and possibly unable to go back to sleep? Is there an increase in irritability or restlessness? Anxiety is often prevalent in patients with chronic respiratory disease, so you may be able to relate the anxiety to increased respiratory difficulty. Consult with family member(s) or caregiver with knowledge of patient behavior.

OASIS ITEM:

(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.)

- ☐ 1 - Depressed mood (e.g., feeling sad, tearful)
- ☐ 2 - Sense of failure or self reproach
- ☐ 3 - Hopelessness
- ☐ 4 - Recurrent thoughts of death
- ☐ 5 - Thoughts of suicide
- ☐ 6 - None of the above feelings observed or reported

DEFINITION:

Identifies presence of symptoms of depression.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Feelings may be observed by the clinician or reported by the patient, family, or others.

ASSESSMENT STRATEGIES:

Observe for indicators of these feelings throughout the assessment. Validate initial impressions with interview questions, (e.g., "I noticed that---. Can you describe your mood for me?").

Follow the suggested protocol on page 8.82 to assess for presence of any depressive symptoms. If depressive feelings are present, inquire about the presence of suicidal thoughts. (If suicidal thoughts are present, inquire whether these have evolved into a plan for self-harm.)

OASIS ITEM:

(M0600) Patient Behaviors (Reported or Observed): (Mark all that apply.)

- ☐ 1 - Indecisiveness, lack of concentration
- ☐ 2 - Diminished interest in most activities
- ☐ 3 - Sleep disturbances
- ☐ 4 - Recent change in appetite or weight
- ☐ 5 - Agitation
- ☐ 6 - A suicide attempt
- ☐ 7 - None of the above behaviors observed or reported

DEFINITION:

Identifies presence of depressive symptoms.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Behaviors may be observed by the clinician or reported by the patient, family, or others.

ASSESSMENT STRATEGIES:

Observe for presence of these behaviors throughout the assessment. Validate initial impressions with interview questions, (e.g., "I noticed that---. Are you having problems with ---?").

Interview for presence of these behaviors in the health history. Follow the suggested interview protocol. If depressive symptoms are present, inquire about the presence of suicidal thoughts. (If suicidal thoughts are present, inquire whether these have evolved into a plan for self-harm or whether an actual attempt has ever been made.)

OASIS ITEM:

(M0610) Behaviors Demonstrated <u>at Least Once a Week</u> (Reported or Observed): (Mark all that apply.)

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

DEFINITION:

Identifies specific behaviors which may reflect alterations in a patient's cognitive or neuro/emotional status.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Behaviors may be observed by the clinician or reported by the patient, family, or others.

ASSESSMENT STRATEGIES:

Observe patient for the presence of these behaviors throughout the entire assessment. If present, validate the frequency of their occurrence. In the health history, interview for the current presence of these behaviors at the stated frequency, i.e., at least weekly. Consult with family or caregiver familiar with patient behavior.

OASIS ITEM:

(M0620) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):

- ☐ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

DEFINITION:

Identifies frequency of behavior problems which may reflect an alteration in a patient's cognitive or neuro/ emotional status. "Behavior problems" are not limited to only those identified in M0610. For example, "wandering" is included as an additional behavior problem. Any behavior of concern for the patient's safety or social environment can be regarded as a problem behavior.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Behavior problems may be observed by the clinician or reported by the patient, family, or others.

ASSESSMENT STRATEGIES:

Observe patient for the presence of these behaviors throughout the entire assessment. If present, validate the frequency of their occurrence. In the health history, interview for the presence of these behaviors at the stated frequency, over a period of time sufficient to determine the current frequency of occurrence. Consult with family or caregiver familiar with patient behavior.